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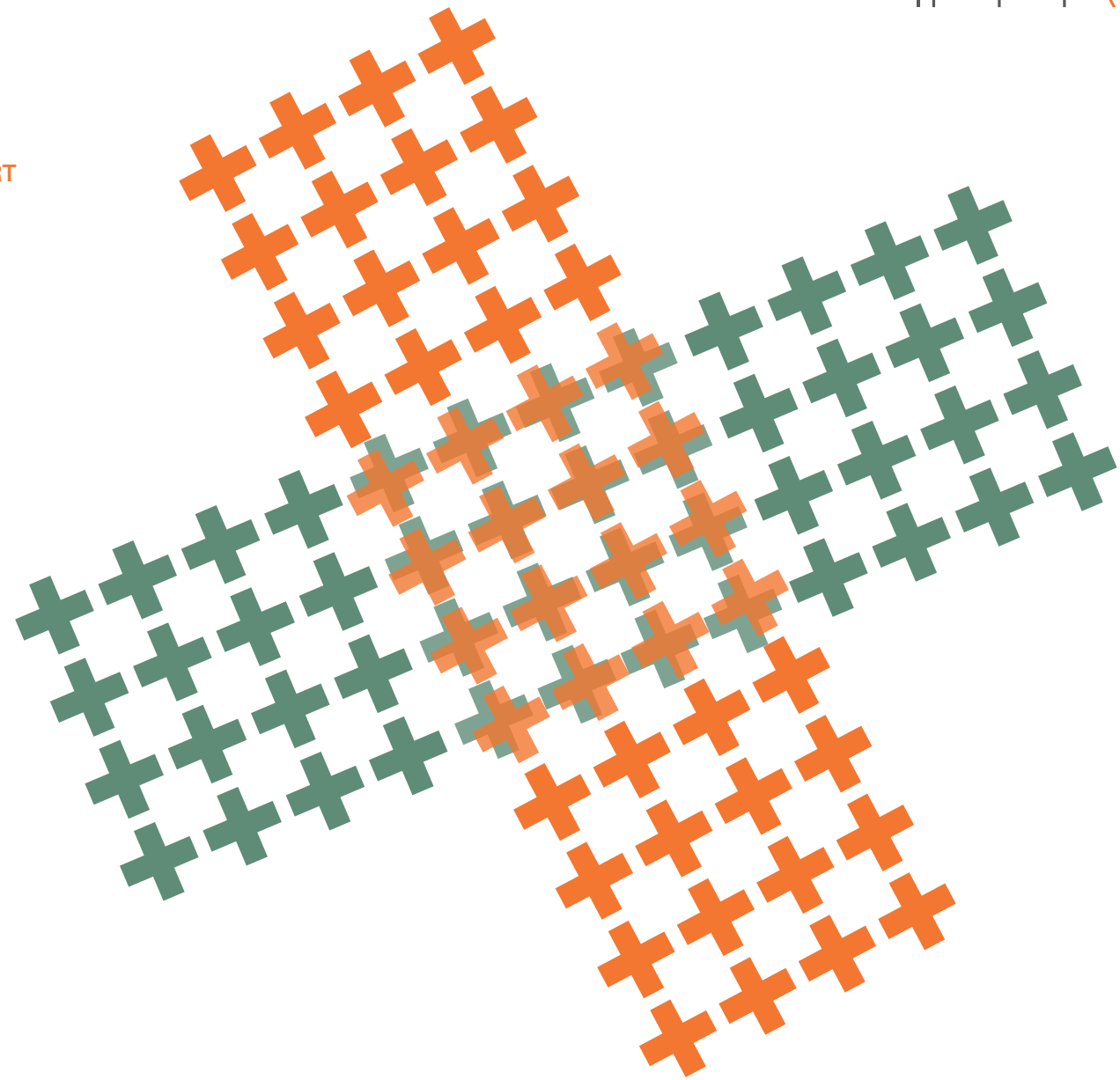

TOWARDS WHOLE PERSON CARE

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NEW IDEAS
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EXECUTIVE SUMMARY

The shadow secretary of state for health, Andy Burnham MP, has called for reform to England's health and care system to deliver whole person care. There are two core elements to this vision: making the connections between physical health, mental health and social care needs, and supporting people to remain in their own homes as long as they wish. The intention is both to improve outcomes and to deliver better value for the money we spend on health and social care. Burnham has said that any changes are to be delivered within existing resources and without a top-down reorganisation.[1]

The different countries of the UK are at different points on the journey towards more integrated care. This paper reviews the case for change in the English health and care system and considers how to move towards a 'whole person care' approach. It sets out broad themes that we intend to return to in IPPR's wider work on creating a health and care system that is fit for the future; it does not, however, provide detailed analysis of technical changes needed.

The evidence suggests that coordinating care around individuals is far more important than integrating structures. The focus should be on 'hiding the wiring' so that people experience seamless care, whether it is from a single provider or multiple organisations. The changes that make the biggest difference to a patient's experience happen at the level of the individual, not the organisation, and are often concerned with the relational aspects of care, such as whether people have their questions answered and can see the same professionals each time they contact services.

Lessons from the many varied examples of efforts to provide more coordinated care in England and other countries suggest that important factors for moving towards whole person care include a long-term investment mindset, incentives for achieving collaboration, effective use of technology and a flexible workforce. There is a clear case for a shift towards whole person care to improve people's experience of interacting with the health and social care system and to improve health and wellbeing outcomes, especially for people with long-term conditions and older people. There is also some evidence that this type of care could save money by reducing the demand for more expensive care such as hospital services, though this has not been consistently demonstrated. Nevertheless, whole person care would represent a wiser use of public money if it delivered better outcomes for the money currently spent on health and social care.

As more and more people live for decades with long-term conditions like diabetes and heart disease, the vast majority of their treatment is self-care at home. Moving towards whole person care must start with the person not the system and focus on delivering humanised, flexible care that can tackle issues like loneliness as well as medical needs. We recommend that a number of person-centred guarantees are at the heart of the vision for whole person care, focused on people with long-term conditions and older people:

- a single point of contact for all care needs
- access to other people with the same condition who can provide peer support
- online access to personal health and care records and the ability to share these
- a personalised care plan covering health and social care
- the option of a personal budget, where this is helpful.

1 See Burnham 2013a

The way that services are organised will need to change to deliver whole person care. There is a range of potential models, including examples led by hospitals and others led by GPs. A single top-down solution would be unlikely to be appropriate in all areas, so we recommend that local areas are given the power and freedom to develop local models. These may be fully integrated organisations or networks of providers, but will need to involve both GPs and hospitals to ensure that the entire care pathway is coordinated. Local authorities must also be involved in their role as social care providers but also as providers of advice and support to everyone accessing social care (whether state-funded or self-funded).

The way services are planned and paid for will also need to change if these models are to develop. We recommend that health and wellbeing boards take greater responsibility for signing off high-level investment decisions across health and social care, based on a partnership of equals and without undermining the role of clinical commissioning groups. This responsibility should be introduced in phases, beginning with spending on older people and people with long-term conditions.

Health and wellbeing boards should ensure that the total local public funding for health and wellbeing is spent in the most efficient way to improve outcomes for these groups who stand to benefit the most from more coordinated care. This may be through pooled budgets, joint commissioning or other delegated authority arrangements – all of which are possible within the existing statutory framework. The current NHS system of paying hospitals for activity and paying community-based services under a block contract creates a financial incentive to treat as many people as possible in hospital and as few as possible in the community. Commissioners should remove this disincentive by linking payments for more integrated providers – or collaborations of providers – to the outcomes they deliver, rather than paying individual providers for the activity they undertake.

Consistent leadership and a long-term investment mindset are crucial for moving towards whole person care and we recommend that a 10-year time horizon is set out at the national level. We currently spend approximately £120 billion on the NHS, public health and social care and monitor the effectiveness of this spend against three different outcomes frameworks. A combined budget should be set for between five and 10 years, and there should be a single outcomes framework covering older people and those with long-term conditions for monitoring local areas' progress.

There is clear local enthusiasm for delivering more integrated health and social care services. Moves towards whole person care should build on this momentum rather than unpick it, making this the core aim of service improvement over the next decade, with the same political focus that waiting times have had in the past. There is clear potential to deliver better outcomes for the money we spend on health and care if services are more coordinated and support people, their families and communities to manage their health more effectively.

INTRODUCTION

The NHS is a health system we can be proud of; and along with social care services, it provides high quality care the vast majority of the time. In 2010, the NHS ranked second in a comparison of health systems across seven high income countries (Davis et al 2010) and public satisfaction with it is just over 60 per cent (NatCen 2013). But it is stuck in the last century, and out of touch with the health and care needs of many people today. The nature of the problem has changed – from acute disease to chronic disease – and it is clear that both the health and care parts of the system have yet to catch up with the realities of an ageing population. Despite controversy over the recent NHS reforms, there is an unusual degree of consensus on the challenges facing the health and care system. Dealing with physical health, mental health and social care needs separately makes no sense at a time when people increasingly depend on all three types of support.

The shadow secretary of state for health, Andy Burnham MP, has called for reform to England's health and care system to deliver whole person care, which he describes as bringing together physical health, mental health and social care into a single service with a single budget. He talks about a service that is responsive to people and organised around their needs rather than around the convenience of institutions: 'a service that starts with what people want – to stay comfortable at home – and is built around them' (Burnham 2013a). There are two core elements. The first is the links between physical health, mental health and social care needs. The second is support for people to remain in their own homes as long as they wish to (rather than opting for hospital or residential care). He has also said that any changes are to be delivered within existing resources and without a top-down reorganisation (see Burnham 2013b).

These themes are neither new nor unique to this country; the House of Commons health select committee has noted that the lack of coordination between health and social services was flagged up in the 1960s and that integration has been a recurring goal in public policy ever since (HCHSC 2012). However, there is now a growing momentum to provide more coordinated care that keeps people out of hospital. In recent years there have been repeated policy statements and pilot schemes targeting the issue.

The different countries of the United Kingdom are at different points on the journey towards more integrated care. Northern Ireland has had structural integration of health and social care since 1973, Scotland is legislating for new health and social care partnerships and Wales is still at an early stage (Ham et al 2013). This paper addresses the specific issues around moving towards whole person care in the English health and care system.

The Coalition government has made integrated health and social care a priority, with three main areas of action:

- health and wellbeing boards, which aim to bring together local partners to promote integrated service delivery (Humphries and Galea 2013)
- the Integration Transformation Fund consisting of £3.8 billion to spend on joining up health and social care services (Downs and McCarthy 2013)
- integration pioneers: 14 'exemplar areas' taking innovative approaches to delivering more coordinated care (DoH 2013a).

However, the NHS and social care are still very different systems – not least because of their funding. The NHS is provided on a free at the point of use basis and funded through general taxation. Social care is means-tested and many people have to make some financial contribution to their care; in fact 45 per cent of those in residential care and 20 per cent of those receiving home care are estimated to be funding all their care (CQC 2012). Mental health services to some extent span both systems, but are predominantly delivered through the NHS.

Commentators have frequently pointed out (see for example Goodwin et al 2012) that these different funding systems are major barriers to greater integration. This is made even worse by the fact that in practice, the boundaries between NHS and social care services are often hard to define (see for example Loux et al 2000). The Coalition government is taking steps to implement a cap on care costs and to implement other reforms that will see a shift towards greater public funding of social care (DoH 2013c), and the Labour party is consulting on whether it is possible to move to an 'all-in' system in which social care is provided free at the point of use (Labour Party 2013). A unified funding system would certainly make integration simpler, but as the multiple examples of good practice in the current system demonstrate it is not a pre-requisite for integrated care. In fact, people who fund their own social care may experience even more problems than those whose care is state-funded.

Another issue is the language which is used to discuss the issues. The terms 'integration', 'coordinated care' and 'joined-up services' are often used interchangeably and in widely varying contexts – from greater coordination between GPs and hospital to better coordination among health, social care, housing, employment and other services. Here, they are used in terms of improved coordination both within the NHS and between the NHS and other local services, predominantly social care.

This paper considers the case for moving towards whole person care, focusing on the opportunities both for improving health and wellbeing outcomes and for saving money. It reviews the literature to understand what conditions are needed in order to deliver more coordinated care and considers what whole person care might look like, on the basis of existing case studies. Finally, it makes recommendations for national and local actions to move towards whole person care.

1. THE CASE FOR CHANGE

A system that addresses the physical health, mental health and social care needs of individuals holistically is better for everyone. However, some groups would particularly benefit from it. The people experiencing the greatest problems with poor coordination between services and with the most to gain from greater integration are older people, people with long term conditions or others with 'complex' needs. These groups are growing dramatically, which means that change across all health and care systems is increasingly necessary.

In England, a third of people have at least one chronic condition and numbers are rising, driven by ageing and lifestyle factors (DoH 2012). Many older people have more than one chronic condition, such as diabetes combined with dementia. Poor physical health is linked to poor mental health and vice versa; 30 per cent of people with a physical long-term condition also have mental health problems (Naylor et al 2012). Mental illness now accounts for nearly half of all ill health in people aged under 65 (CfEP 2012) and many mental health conditions are themselves chronic in nature. In addition, people from more deprived socioeconomic groups are at greater risk of developing a chronic condition.

A lack of coordination among health and care services is a major cause of frustration, along with provision that does not meet people's needs, such as 15-minute time slots for social care visits (see for example Unison 2013). People place a high value on continuity in their care and on being able to build a relationship with the same professional, but this is often not what they experience.[2] Many face delays and barriers to accessing services, are left without support when they are discharged from a service, and need to chase information and repeat themselves (National Voices 2012). Three-quarters of people with anxiety and depression receive no treatment at all (CfEP 2012). Others undergo multiple distressing hospital admissions, even though it is accepted that some of these could be avoided if better care was in place (Blunt 2013). In hospital, their medical needs may be addressed, but basic personal care needs such as help with toileting and eating are not always met (CQC 2011). On top of this, people sometimes stay in hospital longer than they need to, because the right support is not available to help them manage at home (see for example NAO 2013).

A 2010 Commonwealth Fund report compared seven developed-world healthcare systems and ranked the NHS top for effective care and efficiency, but bottom for patient-centred care (Davis et al 2010). While this may matter less to those seeking one-off treatment for an acute health issue, it has a significant impact on people who have lifelong conditions that cannot be cured but only managed. It is the non-clinical aspects of a person's needs that are most often neglected in the current system: and joining up services to address these needs can produce better outcomes and better value. For example, malnutrition is prevalent in the community, in hospitals and in residential care homes with associated health and social care costs estimated at £13 billion (Brotherton et al 2012). Loneliness is estimated to have the same impact on health as smoking up to 15 cigarettes a day (Bolton 2012). Simple interventions like a volunteer delivering a hot meal can make a big difference to these, but because services operate in isolation from each other the opportunities are not being picked up.

Efforts to provide more coordinated care through more integrated services, and a focus on supporting individuals to manage their own health have shown positive impacts on health and wellbeing outcomes.

2 See an upcoming paper on the 'relational state' by Rick Muir and Imogen Parker, to be published by IPPR in January 2014.

For example:

- Integrated health and care teams in Torbay have seen a reduction in emergency bed use by older people, the elimination of delayed transfers between services and high patient satisfaction (Goodwin et al 2012).
- In the US, integrated systems like the Veterans Health Administration and Kaiser Permanente deliver high-quality care and have high patient satisfaction (Asch et al 2004).
- Five NHS examples of coordinated care for people with long-term conditions showed positive outcomes including patient and carer empowerment, improved quality of life and high staff satisfaction (Goodwin et al 2013).[3]

There is evidence that more coordinated care can facilitate earlier intervention to deal with problems and reduce the demand for GP consultations, outpatient visits and emergency admissions. People with chronic health conditions do not want to be admitted to hospital unless it is absolutely necessary (DoH 2012), and if they can access services and support where they live they are less likely to have to be admitted. The picture at the moment is very mixed, however.

- The national evaluation of the NHS Evercare programme found that patients and carers were very satisfied with the service they received, but there was no overall effect on emergency hospital admissions (Boaden et al 2006).
- The national evaluation of the Expert Patients programme found improvements in self-efficacy and quality of life and high patient satisfaction with the programme. There were some reductions in the cost of hospital use (inpatient stays and day cases) but no impact on routine health usage (GPs, practice nurses and outpatient visits) (Rogers et al 2006).
- The national evaluation of the Partnerships for Older People projects reported that staff believed the changes had improved services for older people in terms of their quality of life and wellbeing. It was difficult to assess the impact on older people and the range of measures the evaluation used produced mixed results across the sites. Overall, it found that overnight hospital stays were reduced by 47 per cent and A&E use was reduced by 29 per cent (Windle et al 2010). However, later analysis by the Nuffield Trust using matched controls found no reduction in emergency admissions (Bardsley et al 2013).
- The national evaluation of the Department of Health Integrated Care pilots found that staff reported improvements in care, most of which were process-related, but that patients did not appear to share the sense of improvement. There was some evidence of reductions in inpatient and outpatient costs but no reduction in emergency admissions (RAND Europe 2012).
- The Nuffield Trust's evaluation of the first year of the north-west London Integrated Care pilot found that health professionals believed the pilot had improved collaboration across the system. There was no significant reduction in emergency admissions (Bardsley et al 2013).

Nevertheless, the large variation across the country in the rate of emergency hospital admissions for conditions which can be managed out of hospital suggests that there is potential for improvement. Recent work by the Health Foundation and the Nuffield Trust

3 The five case studies in the report were Midhurst Macmillan Community Specialist Palliative Care Service, Oxleas Advanced Dementia Service, Pembrokeshire community resource teams, Sandwell Esteem Team, South Devon and Torbay.

suggests that 20 per cent of emergency admissions are potentially avoidable and that there is considerable variation between areas, not all of which is the result of relative deprivation (Blunt 2013). Given that the 30 per cent of the population with one or more chronic condition accounts for 70 per cent of all health and care spend (DH 2012), any reductions in hospital use (the most expensive type of care) will produce economic benefits.

The National Audit Office reports that many emergency admissions are avoidable and that many people stay in hospital longer than is necessary (NAO 2013). It suggests that one way to reduce these admissions is for primary, community and social care to manage long-term conditions more effectively. In 2011, the Audit Commission reported that joint working between the NHS and local authorities had the potential to deliver significant savings, although it could identify few examples where this could be demonstrated in practice. It recommended focusing on reducing emergency admissions and estimated that if all areas with greater than expected numbers of emergency admissions for people aged 65 and over had in fact seen the expected number, primary care trusts would have saved £132 million between 2009 and 2010 (Audit Commission 2011). International comparisons also show that some health systems make less use of hospital beds than the NHS does (Ham et al 2003), again suggesting there is scope to reduce admissions by providing better care for people with chronic conditions.

There is a clear case for a shift towards whole person care to improve people's experience of the health and social care system and to improve health and wellbeing outcomes, especially for people with long term conditions and older people. There is some evidence that this type of care could save money by reducing demand for more expensive

services, but this has not been consistently demonstrated. Nevertheless, whole person care would represent a wiser use of public money if it delivered better outcomes for the money currently spent on health and social care. In the next section we draw on previous experiences to identify the factors that can make whole person care more successful.

2. WHAT CONDITIONS ARE NEEDED TO DELIVER WHOLE PERSON CARE?

There are multiple examples of attempts in England and other countries to improve care coordination through more integrated services. We have already noted (see Introduction) that terms like 'coordination' and 'integration' are used to mean different things, so the practical examples do vary quite widely. Natasha Curry and Chris Ham (2010) provide a typology of integration, differentiating between horizontal (for example, community health and social care services) and vertical integration (for example, hospital services and community health services); as well as real (organisational) and virtual integration (based around networks, partnerships and alliances). Finally, they identify three levels of integration: macro (for a whole population), meso (for a particular group such as older people or people with diabetes) and micro (for individuals).

This chapter looks at the existing literature to understand the broad conditions that are likely to be necessary for delivering integrated systems and more coordinated care successfully. Four factors stand out.

A long-term investment mindset

Integrating services and providing more coordinated care is a long-term project and requires up-front investment; in fact, the idea that it costs before it pays has been cited as a 'law of integration' (Leutz 2005). The evaluation of the first year of the north-west London integrated care pilot noted that it would take a minimum of three to five years to show impacts on activity, experience and outcomes (Bardsley et al 2013). This up-front investment, for example in primary and community care and technology, is likely to be needed before any reductions in hospital use are seen. The key point emerging from a Nuffield Trust review of evaluations of projects aiming to provide integrated community-based services was: 'recognise that planning and implementing large-scale service changes takes time' (Bardsley et al 2013).

The investment is more than financial too. The success of Torbay's integrated health and care teams has been attributed to steady local leadership which managed to steer the project through multiple national policy changes, and the focus on the fictional older person 'Mrs Smith' who would ultimately benefit from improved care (Thistlethwaite 2011). Leaders at Kaiser Permanente note that high patient satisfaction has created very loyal members, and this is what has given the health maintenance organisation the security to invest in long-term preventative medicine (Levine 2012).

Aligned incentives

Incentives need to encourage collaboration to achieve shared goals rather than creating competing interests that lead to fragmentation. Goodwin et al (2012) identify various options for improving incentives but they all focus on paying for outcomes and holding providers jointly accountable – encouraging both collaboration and investment in proactive preventative care. At Kaiser Permanente and the Veterans Health Administration, capitated budgets tie all parts of the system together by making their success mutually dependent (Curry and Ham 2010). In Torbay, there is a single provider and single budget for health and social care (Thistlethwaite 2011).

Edward Wagner (2001), Chris Ham (2010) and Kenneth Kizer (2012) all agree on the importance of aligning incentives to support a shift towards more coordinated and preventative care, but also note that it may be just as important to remove disincentives. The current NHS system of paying hospitals for activity and paying community-based services under a block contract creates a financial incentive to treat as many people as possible in hospital and as few as possible in the community (Lewis et al 2010).

This is appropriate for discrete episodes of planned treatment for acute conditions, but it is far less appropriate for chronic conditions where a hospital admission often shows that the other forms of care and support have failed.

Effective use of technology

If services are to connect with each other, it is essential that they share the information about service users. People should only have to provide their details once, and this data should be captured on behalf of multiple agencies. There are also benefits from systems that allow patients and carers to access their records and communicate with services online, and technology can also make it possible for people to manage their own conditions and stay at home for longer.

The US systems are ahead of the NHS in their use of technology. Kaiser Permanente's HealthConnect system allows people to access their own medical records, make appointments online and order prescription refills, as well as deliver patient education to support self-management (Curry and Ham 2010). An electronic patient record system was introduced throughout the Veterans Health Administration and a care coordination/home telehealth system was also established to allow remote monitoring of people at home (Oliver 2008).

Use of technology in the NHS is under-developed, with the £10-billion National Programme for IT criticised for failing to deliver, going over budget and failing to meet expectations where products were delivered (HCPAC 2013). The King's Fund concluded that the programme focused too much on developing the infrastructure to underpin internal NHS information systems, and not enough on the interface between patients and the NHS (Liddle et al 2008). Goodwin et al (2012) noted that 'the absence of a robust shared electronic patient record that is accessible to and used by all those involved in providing care to people with complex conditions is a major drawback to supporting a more appropriate and integrated response to people's needs'.

Flexible workforce

Delivering more coordinated care requires a workforce that is flexible and able to work across traditional divides between health and care, and mental health and physical health. Professionals also need to be willing to work with people and their families as equal partners who should be supported in managing their own health. However, there are dramatic differences between the English health and social care workforces. Many care workers are paid at (or even below) the minimum wage and in general social care is seen as a lower status profession than healthcare (Pennycook 2013).

Efforts to improve integration have tended to be built around community-based multi-disciplinary teams, often including a specific role of care coordinator (Goodwin et al 2013). A recent review found good evidence for creating new roles working across professional boundaries and found that a shared focus on the user helped to overcome divisions (Institute for Public Care 2013). Certainly, the care coordinator role can be delivered in different ways. In Torbay, for example, the care coordinators have no professional background: 'coordinators do not have formal professional training but know how to harness the contribution of team members to improve the care of Mrs Smith and people like her' (Thistlethwaite 2011). In Cornwall's integrated care pilot, staff and volunteers from Age UK Cornwall provide the coordination function (Creaven 2013). In virtual ward arrangements, it is usually the 'ward clerk' who can be contacted by phone and email and who passes information between key staff and patients (Lewis et al 2011).

3. WHAT ARE THE DIFFERENT OPTIONS FOR DELIVERING WHOLE PERSON CARE?

Coordinated care is more important than structural integration

Reviewing the evidence in this area, it seems clear that coordinated care is more important than structurally integrated services. As National Voices concluded, people want good care and they do not care where it comes from as long as professionals work together (National Voices 2012). Organisational boundaries are meaningless to patients and carers. Structural integration alone does not appear to deliver improved outcomes: for example, Northern Ireland has had structurally integrated health and social care since 1973 but has not managed to translate this into significant improvements in the care people receive (Ham et al 2013). This seems to be because social care was integrated into health boards in order to address capacity issues, rather than with the aim of improving care. The King's Fund and the Nuffield Trust are clear throughout their work that 'organisational integration appears to be neither necessary nor sufficient to deliver the benefits of integrated care' (Goodwin et al 2012).

The focus should be on 'hiding the wiring' so that people experience seamless care, whether it is from a single organisation or multiple agencies. The changes that make a difference to people's experience happen at the level of the individual, not the organisation. The factors most likely to produce a positive experience are the *relational* aspects of care, such as being listened to, having questions answered and sharing in decisions (National Voices 2011, 2012). A report for the National Institute for Health Research that included older people as researchers found that the way older people were treated by professionals had a considerable impact on their experience (Ellins et al 2012). The report calls for 'micro-changes' in the care environment and in interpersonal relationships, particularly to prioritise the continuity that allows older people to get to know a particular member of staff. In general it is clear that moving towards whole person care predominantly requires cultural change on a significant scale and will not be delivered simply by reorganising structures.

Whole person care should be about putting people in control

When people have a one-off interaction with the NHS for a prescription or planned operation, they may be less interested in being involved in planning their care than in the speed, convenience and effectiveness of their treatment. But when people live with a condition for many years they provide the vast majority of care themselves and so the effectiveness of this 'self-management' becomes absolutely crucial. Lifestyle factors like physical activity, social isolation, diet, smoking and alcohol consumption have a big impact on outcomes for people with long-term conditions. For example, high levels of physical activity and quitting smoking are associated with fewer hospital admissions for people with chronic obstructive pulmonary disease (Morgan 2003, Godtfredsen et al 2002).

High-quality care should focus on enabling individuals to manage their own condition in order to slow down its progression or prevent their problems worsening and requiring hospital or residential care (Ham 2010). Clinicians and other health and care practitioners therefore need to work with people and with communities to support them to take control of their health and the care they receive. Supporting self-management often involves working closely with families, carers, and the wider community, particularly with other people who have the same condition ('peer supporters'). The Health Foundation's review of studies into the effectiveness of self-management found evidence that strategies led by users, or in partnership with users and professionals had positive outcomes (De Silva 2011). The King's Fund found that efforts to coordinate care flourished at the neighbourhood level; they benefited from engaged communities by drawing in the voluntary sector, using volunteers in their care programmes and building awareness and trust among the local population (Goodwin et al 2013).

Personal budgets can play a great part in this, because they put people in control of their health and the treatment they receive. Evaluations of personal budgets in social care and health have found a range of benefits including greater independence and improved quality of life and wellbeing (Think Local Act Personal 2013, Forder et al 2012). They have been found to deliver good value for money, and there is some evidence that personal health budgets have reduced costs for inpatient, emergency care and GP services, suggesting that people were managing their health better and lowering their need for other services (Forder et al 2012).

Integrating health and social care personal budgets removes the organisational barriers completely, and allows people to arrange the care they want to meet their needs, regardless of where it comes from or who is paying for it. Personal budgets can also help to break down barriers between those who receive state-funded social care and those who self-fund, ensuring that everyone receives the support they need to arrange the right care for them. This does raise the question of 'topping-up' public funding, which is currently prohibited in the NHS although allowed in social care; if personal health and social care budgets are integrated it is hard to see how to avoid individuals topping these up should they choose to.

Integrated care organisations or networks could be led by hospitals or GPs – but must include both as well as local authorities

It is clear that the way services are organised will need to change, not least because the current model of hospital provision appears unsustainable in many areas (Ham et al 2013). On top of the pressure to shift general care into the community, hospitals are also under pressure to centralise specialist services to improve quality and safety (Monitor 2013). Both reforms have widespread clinical backing and numerous reports have made the case for changes to hospitals (NHS Confederation 2013). However, the public tends to oppose changes to local health services, even when backed by clinicians and evidence that safety and quality will improve (Barrat and Raine 2012). An IPPR briefing on hospital reconfigurations some years ago set out the case for change and noted the likely public opposition, demonstrating that these are not new issues (IPPR 2006).

Over half of NHS leaders have said that it is extremely hard to convince the public of the need for change (NHS Confederation 2013). Reports in the media of changes to services usually focus on closures or downgrades, which further fuels public anxiety. The public does not always trust that new services in the community will materialise if hospital services are reduced, leading to an understandable desire to protect the services that exist. Hospitals are highly valued community assets and politicians know that changes to hospitals are an issue on which parliamentary seats are won and lost. There are numerous examples of MPs opposing local changes, even as their party calls for such changes nationally. Two-thirds of NHS leaders say that political resistance is the greatest barrier they face in redesigning services (NHS Confederation 2013).

There are multiple potential models for future service provision and local differences (for example, rural compared to urban areas) mean it is unlikely that a single model of provision imposed top-down would be appropriate. Again, the King's Fund and Nuffield Trust are clear that no single 'best practice' model of integrated care exists (Goodwin et al 2012). The national evaluation of the Department of Health Integrated Care pilots found that 'integrated care comes in many shapes and sizes' (RAND 2009) and the House of Commons health select committee said it was 'wary of recommending a single structural solution' (HCHSC 2012).

Moving towards whole person care and delivering transformational change across the country also requires more integrated providers or networks of providers. Given the diversity of providers that need to be involved in whole person care, it is unlikely that single organisations could cover every aspect of care, however comprehensive and integrated they are. To illustrate the complexity of service provision in England, just 13 per cent of adult social care jobs are in the public sector (CQC 2012), and around 35,000 voluntary sector organisations provide health and social care (IFF Research 2007). Furthermore, the crucial role of housing, employment and other local facilities in health and wellbeing means that well-functioning networks that allow wider collaboration will be necessary even with more integrated organisations.

There are two obvious points from which more integrated providers or networks could develop: local hospitals or groups of GPs. Social care providers are generally less embedded in the communities they serve than either of these, and also seem less likely to become lead providers of integrated health and social care. Local government clearly has a crucial role too, but councils are primarily commissioners rather than providers of social care. As such, they should be equal partners with clinical commissioning groups in planning care through health and wellbeing boards (as we discuss below), but they are unlikely to be the lead organisation in a provider network.

The Labour party is looking at whether district general hospitals could 'evolve over time into integrated care providers and shift the focus of services towards prevention' (Labour Party 2013). The clear advantage of such a model is that it provides a positive future for local hospitals and builds on their strength as the visible 'bricks and mortar' of the NHS, which attract such public affection. The risk is that they use this new role to protect the status quo rather than develop new models of care in the community (Ham 2013). However, there are several examples of hospital trusts leading the development of more integrated care organisations.

- Northumbria Healthcare NHS Foundation Trust provides hospital, community health and adult social care services in Northumberland, focusing specifically on delivering integrated care pathways for older people including a single point of access to care.[4]
- The Heart of England NHS Foundation Trust is working to develop the local hospital in Solihull into an 'integrated care hub' providing a care navigation service and bringing together partners across primary, secondary, mental health, social care and the voluntary sector.[5]
- South Warwickshire NHS Foundation Trust provides hospital and community health services and is working with GPs, voluntary sector partners and social care to integrate care for older people.[6]
- The Whittington Hospital NHS Trust provides hospital, community health and adult social care services in Islington and is working with GPs as providers and commissioners to deliver more integrated care.[7]

Foundation trusts could potentially become leaders of new integrated provider networks and hold capitated budgets for a set population. They would be held to account for the

4 See https://www.northumbria.nhs.uk/about-us

5 See http://www.heartofengland.nhs.uk/?page_id=78

6 See http://www.bgsnet.org.uk/index.php/news-archive-html/2012news/nov12/104-nov12-southwarwickshre-case-study

7 See http://www.whittington.nhs.uk/document.ashx?id=2465

outcomes they delivered for that population, in partnership with GP practices and other providers in the network (Goodwin et al 2012).[8]

In other areas, GPs themselves are leading projects to deliver more coordinated care. Embedded in the community, enjoying high levels of public trust, and already providing 90 per cent of NHS care (RCGP 2013), GPs are well-placed to lead whole person care. Furthermore, the grouping of GP practices into clinical commissioning groups provides a potential foundation on which to build integrated care organisations or networks. There are several examples in the NHS already.

- North East Lincolnshire GP practices are at the heart of teams of consultants, nurses, social workers and others, all working to the same goals to deliver joined-up care.[9]
- Cumbria Clinical Commissioning Group is using GP practice populations as the basis for bringing together community health services and social care.[10]
- GPs in Southwark and Lambeth are bringing together community multi-disciplinary teams including social care, mental health, community nursing and geriatricians.[11]

The best model for a local area will depend on historical relationships, the sustainability of the local hospital (on which geography has a significant impact) and the strength of GPs. It is clear that any successful integrated network must include GPs, hospitals and social care providers as a minimum in order to coordinate throughout the care pathway. Local authorities must also be involved in their role as social care providers but also as providers of advice and support to all those accessing social care (state-funded or self-funded). In a review of five examples of coordinated care, the King's Fund found that a lack of engagement from GPs and weak links with secondary care caused problems (Goodwin et al 2013). We would not recommend imposing a single top-down structure but rather propose that health and wellbeing boards take the lead in working with local communities to develop a solution.

Professor Ara Darzi has described the recommendation in his own interim report to introduce 150 GP-led health centres as 'the wrong approach to integration' because it was 'a very centralised, prescriptive approach where the aim was that all the NHS should adopt the same model'. In contrast, he believes that 'government's responsibility should be to create an environment conducive to locally developed integrated care, not to create universal models for integration unresponsive to local circumstances' (Darzi and Howitt 2012). It is also very important that the integrated providers are valued by communities and can engage people in their activities: for example through volunteering schemes. Quite apart from the intrinsic value of building relationships between citizens and strengthening communities, this type of engagement also strengthens the institutions themselves, making them more resilient and sustainable for the long term.

8 Current competition law would mean that a contract to deliver integrated services in this way would need to be awarded through a competitive tender and there would therefore be no guarantee that foundation trusts would be successful bidders. If competition law were to change, alternative strategies would be needed to maintain pressure for quality improvement.

9 See http://www.northeastlincolnshireccg.nhs.uk/about-us/

10 See http://www.cumbriaccg.nhs.uk/about-us/how-we-make-decisions/governing-body-meetings/2013/2013-08-15/Papers3/15-integrated-health-social-care-pioneer.pdf

11 See http://slicare.org/2412/integrated-care-driven-by-gp-practices-in-southwark-and-lambeth-2/

4. MOVING TOWARDS WHOLE PERSON CARE

Moving towards whole person care must start with the person not the system, and focus on delivering humanised, flexible care that can tackle issues like loneliness as well as medical needs. We recommend a number of guarantees that would make a difference to people's experience. These guarantees would make it easier for individuals and their families to take control of their own health and care so they can stay well and independent at home as long as possible. In addition, the approach of introducing a small number of guarantees would help to explain in simple terms the benefits of whole person care. In this way, it would build public support for change, and help systems to change so that services are better connected and can therefore deliver more coordinated care.

Local enthusiasm for delivering more coordinated care is shown by the fact that the Integration Pioneers programme received over 100 expressions of interest (DoH 2013b). Moves towards whole person care should build on this momentum rather than unpick it, and focus on giving local areas the power and the freedom to implement change. We recommend a stronger role for health and wellbeing boards to oversee joint commissioning and a shift to paying integrated care organisations or networks based on outcomes rather than activity.

It is clear that consistent leadership and a long-term investment mindset are crucial, but there is not a single top-down solution for delivering more integrated care. Nationally, we recommend that a 10-year time horizon be set out for moving towards whole person care. A combined budget should be set for this timeframe and a single outcomes framework used for monitoring local areas' progress.

Person-centred guarantees

We recommend that the following guarantees be placed at the heart of the vision for whole person care. These should be focused on those people who stand to benefit most from integrated care, beginning with people with long-term conditions and older people.

- A single point of contact for all care needs: National Voices (2012) found that people wanted a single point of contact for their care, and the King's Fund points out that successful approaches to care coordination are characterised by a single point of entry (Goodwin et al 2013). The point of contact is usually a 'care coordinator': a role that does not appear to require a clinical background or professional training but does require interpersonal skills and knowledge of the local community. Care coordinators must have the authority to get things done. This could develop into an important new role in a more integrated health and care system, potentially reducing demand for more traditional health and social care services.
- Access to other people with the same condition who can provide peer support: Peer support can make it possible to tap into the expertise of thousands of other people who are learning how to manage the same condition. It can be a very effective (and cost-effective) way to improve outcomes for people with long-term conditions. The more successful self-management approaches tend to focus on behaviour change (De Silva 2011), and emerging insights from behavioural science suggest that behaviour change is reinforced by making public commitments and by receiving information from people we perceive to be similar to us (Dolan et al 2010). Voluntary sector organisations have an important role to play here, because they already have close connections within local communities (NAO 2011), while encouraging people to become peer supporters themselves creates a further community resource for supporting health and wellbeing. There are also online options, such as the website www.HealthUnlocked.com, which brings together over 100 community forums where people discuss specific health conditions.

- Online access to personal health and care records and the ability to share these: Coordinated care is often hampered by concerns over data protection, and as a result organisations are not able to share information. Making it absolutely clear that individuals themselves are the legal owners of their health and care records, and that they have the right to decide who sees this information, should help to overcome this barrier. For this to be a reality, patients and services need to be able to access the records and share them electronically.
- A personalised care plan covering health and social care: Successful approaches to coordinated care are characterised by joint care planning, based on an assessment including carers' needs (Goodwin et al 2013). Care plans need to be tailored to personal circumstances and not restricted by service boundaries. They should cover plans for self-management as well as the support that family, friends and the wider community can contribute. They should also be drawn up as early as possible, in order to maximise the benefits of preventative care, and then reviewed frequently after that.
- The option of a personal budget: In situations where the care planning process reveals that locally commissioned services cannot meet the person's needs, or where they could benefit from a different approach, they should have the option of an integrated health and social care personal budget. However, anyone receiving a personal budget should also to be offered the advice and support they need to use it most effectively.

Most of these measures have been part of national policy for years but they need a renewed commitment if they are to be provided consistently to those who could benefit most. The NHS Constitution currently includes the right to be treated within 18 weeks of referral, the right to choose a hospital, the right to view personal health records and the right to have a complaint acknowledged within three working days and investigated thoroughly.[12] In order to make whole person care the overriding priority for the health and care system in the coming years (in the way that the 18-week waiting time target was in the last decade) we recommend a set of coordinated care entitlements incorporated into the NHS Constitution. These should also be accompanied by meaningful redress. As the 'consumer champion' with a remit spanning both health and social care, Healthwatch could play a valuable role in monitoring and comparing delivery of these guarantees across local areas.

A greater role for health and wellbeing boards

Health and wellbeing boards are the point at which all local stakeholders with an interest in the community's wellbeing come together. They have local responsibility for leading integration and many organisations, including the health select committee, have proposed that their role be strengthened (HCHSC 2012). Sitting within local authorities, the boards have a democratic underpinning, as they include elected councillors; most have senior-level shared leadership, with a senior councillor chair and a representative of the clinical commissioning group acting as vice-chair (Humphries and Galea 2013).

The King's Fund recently reported that the boards have made a strong start but that most seem to see integration and system reform issues as outside their remit (ibid). The boards have been set up in different ways, and not all have executive decision-making powers as committees within local authorities. However, they are responsible for signing off plans to use the £3.8 billion in the Integration Transformation Fund, and this is a first step towards a greater oversight of investment decisions.

12 See http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/handbook-to-the-nhs-constitution.pdf

The local bodies created by the Health and Social Care Act 2012 have created a confusing landscape, and it is not clear who has responsibility – and the power to make decisions – for what. Any further changes to local bodies' responsibilities needs to focus on simplifying decision-making. This is crucial for joining up the different local organisations and involving communities themselves in whole person care.

We recommend that the vision for whole person care includes a greater remit for health and wellbeing boards to sign off high-level investment decisions across health and social care. This would be based on a partnership of equals and must not undermine the clinical leadership of clinical commissioning groups in NHS commissioning. This responsibility should be introduced in phases, building on the boards' oversight of the Integration Transformation Fund, and beginning with spending on older people and people with long-term conditions. This would give them a stronger role in ensuring that the total local public funding for health and wellbeing is being spent in the most efficient way to improve the outcomes of coordinated care.

Health and wellbeing boards should ensure that all funding available in the local area is spent in the most effective way to improve health and wellbeing. This could be through pooled budgets, joint commissioning or other delegated authority arrangements – all of which are possible within the existing statutory framework. The Audit Commission reviewed joint financing arrangements in 2009 and found that the different processes had little impact on users, and that what mattered was focusing on improved outcomes (Audit Commission 2009). Rather than paying individual providers for the activity they undertake, commissioners should shift to paying more integrated providers – or collaborations of providers – for the outcomes they deliver. Linking payment to outcomes such as improved independence and patient satisfaction, and making all providers accountable for these outcomes, will provide incentives for collaborating and coordinating support around individuals' needs.

One example of this type of approach is the Year of Care funding model which creates an annual capitated budget linked to specific levels of need and holds all providers involved in the care pathway accountable through risk-sharing agreements (DoH 2011). A similar approach is Alliance Contracting, in which the commissioner holds a single contract with an alliance of provider organisations who all work to the same outcomes and share any gain or pain associated with overall performance.[13]

A 10-year national plan

A long-term mindset is an important condition for whole person care, and one that struggles to take root in our health and care system. Paul Corrigan (2011) describes the poor track record of the NHS in realising financial benefits from projects that were intended to create savings. However, whole person care is essentially an 'invest-to-save' project and requires a long-term view.

At the moment, commissioners do not know if they will be able to maintain funding for new services long enough to see benefits and realise savings, so they have less incentive to make investments. With slow economic growth and public unwillingness to pay more in taxes, there is unlikely to be additional funding for the foreseeable future. In this context, one way to encourage investment in interventions that are likely to save money further down the line (such as improvements in technology) is to provide a longer-term funding settlement. This would give commissioners the certainty to invest in prevention

13 See http://lhalliances.org.uk/

and the infrastructure needed to connect services, knowing they could sustain funding long enough to realise savings.

For this reason, we recommend that whole person care is described as a 10-year journey. Only by setting out a longer time horizon will people be able to make the necessary investments in capacity in primary and community care. While we realise that it is challenging for the Treasury to commit funds over the long term, especially in the current economic climate, we recommend that a 10-year plan is also matched by stable funding over this period. A five-year funding settlement for health and social care, accompanied by a forecast of the following five years with a model of the demand would underline the government's commitment to whole person care. The House of Lords has also called for a 10-year funding plan for health and social care (HLSC 2013).

The 10-year plan should be accompanied by a commitment that there will not be any top-down structural reorganisations over this time period. Andy Burnham has said he is clear that 'any changes must be delivered through the organisations and structures we inherit in 2015' (Burnham 2013b). Evidence suggests that successive reorganisations tend to delay improvements in outcomes. NHS reorganisations over the last 25 years are estimated to have cumulatively cost billions, and to have had a direct adverse impact on productivity (Dunleavy and Carrera 2012). There is little evidence that top-down reorganisations produce significantly better or worse structures than those they replace, the transition costs are huge, and they adversely affect quality by distracting managerial and clinical attention and destabilising services (Walshe 2010).

Given that no government can bind its successor, a 10-year plan would need some degree of cross-party consensus. In Scotland, where the greatest progress has been made in delivering greater integration in the UK, this success is attributed in part to the fact that there has been no significant reorganisation of structures in 10 years and that all the political parties have agreed on the importance of partnership working to achieve integration (Ham et al 2013).

The Department of Health has overall policy responsibility for the NHS, public health and social care. Spending on these three areas totals approximately £120 billion but is spread across various budgets held by NHS England, clinical commissioning groups and local authorities. We recommend that government not only sets a combined budget for as long a timeframe as possible (between five and 10 years), but that it links this global budget to a set of outcomes that should be delivered across the health and care system. Currently, the Department of Health issues three separate outcomes frameworks for the NHS, public health and social care, which only reinforces their fragmentation. Other elements have come together in recent years to cover the whole health and care system such as the National Institute for Clinical Excellence and the Care Quality Commission, so it is a logical step to bring the outcomes frameworks together. If all parts of the system share accountability, they will have the incentive to work together to improve performance. As with our other recommendations, the first step should be a single outcomes framework for people with long-term conditions and older people.

CONCLUSION

Moves towards whole person care should build on the current enthusiasm for integrating services but go much further in making this the core aim of service improvement over the next decade, with the same political focus that waiting times have had in the past. There is clear potential to deliver better outcomes for the £120 billion we spend on health and care if services are more coordinated and support people, their families and communities to manage their health more effectively.

Reviewing the evidence on service integration and care coordination, it is clear that efforts have been most successful where they focus on improving outcomes. This must be the key principle for moving towards whole person care.

There are many issues, such as workforce, that require more attention, as they are critical to the success of whole person care. Over the next 12 months, IPPR will carry out further work looking at how to create a health and care system that is fit for the future, and we will return to the themes outlined in this paper, particularly the potential for people to take more control of their health.

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